Health Care Authority
Grievance System and Non Participating Provider Reporting Instructions
(Effective July 1, 2012)

Non Participating Provider Reporting:

The Managed Care Organization (MCO) will provide the following information to the Health Care Authority (HCA); two reports one for Healthy Options and one for the Basic Health line of business; every 2nd Wednesday of August of each year with the submission of the Grievance, Action and Appeal report (or upon HCA request):

1. **Column B:** The total cost of overall services (claims paid), per county paid to all providers for services provided to enrollees served under the Contract for the timeframe of August – July of the preceding fiscal year.
2. **Column C:** The percent of overall cost of services (claims paid), per county, paid to non participating providers, including hospital-based physician services, provided to enrollees served under the Contract for the timeframe of August – July of the preceding fiscal year.

   Data must be provided using the attached EXCEL format in the file titled GAAandNPPformat.xls in the tab identified as NPPrpt2011-2012.

Grievance System Reporting:

Timeframe in which Grievances\Complaints, Actions\Denials and Appeals (GAAs) were received by the MCO.

- 1st Submission = July - December with **Data submission due 2nd Wednesday of February**
- 2nd Submission = January - June with **Data submission due 2nd Wednesday of August**
  - Data must be in EXCEL format as described below and be submitted electronically through the HCA Secure File Transfer (SFT) - also known as Valicert web site. Submitter must send an upload notification to the general Managed Care mailbox at HCAMCPROGRAMS@HCA.WA.GOV.
  - Data must be provided using the attached EXCEL format in the file titled GAAandNPRformat.xls in the tab identified as GAArpt.
  - Submission EXCEL file must be labeled with health plan name, reporting year and quarter (Example: MCO-GAANPPQ2-12).

DEFINITIONS

Action\Denial: An Action\Denial is:

(1) The denial or limited authorization of a requested service, including the type or level of service;
(2) The reduction, suspension, or termination of a previously authorized service;
(3) The denial, in whole or in part, of payment for a service;
(4) The failure to provide services in a timely manner, as defined by the State;
(5) The failure of an MCO to act within the timeframes provided in Sec. 438.408(b); or
(6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under Sec. 438.52(b)(2)(ii), to obtain services outside the network.

Appeal: A formal request by a covered person or provider for reconsideration of a decision such as, but not limited to, a denial, an action other than a denial, a benefit payment, an

administrative action\denial, or quality of care or service issue. An Appeal is a request for the MCO to review an action\denial.

CSHCN: Children with Special Health Care Needs, means children younger than age nineteen who are identified by the department as having special healthcare needs. This includes:

(1) Children designated as having special healthcare needs by the department of health (DOH) and receiving services under the Title V program;

(2) Children eligible for Supplemental Security Income under Title XVI of the Social Security Act (SSA); and

(3) Children who are in foster care or who are served under subsidized adoption.

ESHCN: Enrollees with Special Health Care Needs, an enrollee who has at least two chronic conditions; one chronic condition and be at risk for another chronic condition; or one serious and persistent mental health condition. Enrollees with chronic condition(s) scoring in the highest five percent (5%) of all Medicaid eligibles or have a risk score of 1.5 or greater using the Predictive Risk Intelligence System (PRISM) risk scoring methods, are considered enrollees with special health care needs.

Expedited: An appeal must be expedited if the enrollee's provider or the MCO reasonably determines that the appeal process timelines could seriously jeopardize the enrollee's life, health, or ability to regain maximum function. The decision regarding an expedited appeal must be made within three (3) calendar days after the appeal is received.

Grievance\Complaint: An expression of dissatisfaction about any matter other than an action\denial. The term is also used to refer to the overall system that includes grievances\complaints and appeals handled at the MCO level and access to the State Hearing process.

Grievance\Complaint Example: Possible subjects for grievances\complaints include, but are not limited to, the quality of care or service, access to care, client liability for payment and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.

A grievance\complaint is to be registered and counted as such whether the grievance\complaint is remedied by the plan immediately or through its grievance\complaint and quality of care and service procedures regardless of whether it is substantiated. If an enrollee has a number of different grievances\complaints, each one is to be registered separately.

Any grievance\complaint sent by a state agency (HCA/OIC) is to be registered and counted as such whether the grievance\complaint is remedied by the plan or through its grievance\complaint and quality of care and service procedures regardless of whether it is substantiated.

*Inquiry: A written or verbal question or request for information posed to the plan such as benefit questions, contract issues, or organization rules. Inquiries do not reflect enrollee grievance\complaint or disagreements with plan determinations. Inquiries **are not** to be counted. Example: An ID card request or a request to change PCP is considered an inquiry unless the enrollee is filing a grievance\complaint because previous requests were not answered satisfactorily.*

Practitioner: Practitioner involved in the grievance\complaint, action\denial, or appeal. Practitioners are usually required to be licensed as defined by law. For HCA reporting purposes, a provider is a health care professional such as a physician or any providers acting within

their scope of practice (as defined by 42 CFR 438.2). Examples of Providers\Practitioners: Physician, cardiologist, podiatrist, optometrist, physician assistant, physical therapist, clinical nurse specialist, registered or practical nurse, pharmacist.

Resolution: The final determination by the MCO to resolve the grievance\complaint, action\denial, or appeal.

MCO GAA FORMAT REPORTING GUIDELINES

1. **Column A**: Health Plan Name – Indicate reporting plan with full name or common abbreviation.
2. **Column B:** Delegated Entity – Identify the health plan's delegated entity that receives and takes action on grievances\complaints, actions\denials, or appeals. The health plan is responsible to integrate the delegated entity's data into the health plan's data. There should be no separate data submission for the delegated entities. It is advised that the plan downstream the report instructions and table to facilitate administrative simplification and roll up of combined plan, delegate data.
3. **Column C**: Reporting period – Indicate the reporting period the initial grievance\complaint, or action\denial is received. Reporting format: 1,2
4. **Column D**: Program Name – Specify the program for the data submitted using numbers 1-5 as follows:
    1. BH – Indicates Basic Health and HCTC enrollees.
    2. HO – Includes all Healthy Options (HO; HOBD; HOFC), Basic Health Plus (BH+) and Maternity Benefits Program enrollees
    3. CHIP – Identifies Children's Health Insurance Program enrollees
    4. MCS – When applicable to the reporting health plan. Identifies Medical Care Services former program titles were Disability Lifeline and GAU.
    5. WMIP - When applicable to the reporting health plan. Identifies Washington Medicaid Integration Partnership enrollees
5. **Column E:** ESHCN & CSHCN - Identify all Enrollees and Children with Special Health Care Needs with an "X".
6. **Column F:** Enrollee ID – Populate column with the enrollee's Social Security Number (Basic Health Only) for Healthy Options the enrollees Washington Provider One ID number.
7. **Column G**: Enrollee Last Name
8. **Column H**: Enrollee First Name
9. **Column I**: Enrollee Middle Initial
10. **Column J:** Enrollee Birth Date – Format: MM/DD/YYYY. (Example: 12/01/1985).
11. **Column K**: Provider\Practitioner Last Name – Identifies the servicing provider\practitioner, either as the source of an enrollee's grievance\complaint; or the provider of service the plan took action upon or denied, or is addressing the enrollee's service.
12. **Column L**: Provider\Practitioner First Name

13. **Column M:** Provider\Practitioner Middle Initial

14. **Column N**: Provider\Practitioner Specialty – Identifies type or specialty of practitioner. Should be no more than thirty (30) characters. Examples: Family Practitioner, Chiropractor, Acupuncturist, Surgeon, General Surgeon, Orthopedist, Urologist, Internal Medicine, Certified Nurse Practitioner, Dermatologist, etc.

15. **Column O:** Individual Provider\ Practitioner NPI

16. **Column P**: Facility Name - Identifies the facility or clinic the practitioner is associated or contracted with and which is associated with the grievance\complaint, action\denial, or appeal.

17. **Column Q:** Type\Level – Specifies the category and the level for the data submitted as follows:

    1=Grievance\Complaint

    2=Action\Denial

    3= Appeal

    4=Independent Review Organization (IRO)

    5=State Hearing

18. **Column R**: Expedited – Identifies urgency of the grievance\complaint or appeal. Reporting format: "X" if yes leave blank if no.

19. **Column S**: Category – Describes the "what" or the catalyst for the grievance\complaint, action\denial or appeal. See attached EXCEL file titled "GAA Standard Categories" Tab identified as Column S. **This key descriptive column must be populated for all records. (NOTE: "Other" category should be used sparingly.)**

20. **Column T**: Subcategory - See attached EXCEL file titled "GAA Standard Categories" Tab identified as Column T. **(NOTE: "Other" category should be used sparingly.)**

21. **Column U**: Reason - Describe the "why" the Grievance\Complaint, Action\Denial, Appeal or State Hearing occurred. See attached EXCEL file titled "GAA Standard Categories" Tab identified as Column U. **This key descriptive column must be populated for all records. (NOTE: "Other" category should be used sparingly.)**

22. **Column V**: Resolution – Describe the "outcome" of the grievance\complaint, appeal, IRO, or Hearing determination. This specifies all partial approvals or a plan changes in a service request. See attached EXCEL file titled "GAA Standard Categories" Tab identified as Column V. **This key descriptive column must be populated for all applicable records.**

23. **Column W**: Date Received – Documents the date the grievance\complaint was received, an action\denial took place, or an appeal, IRO, or State Hearing request was received. Reporting format: MM/DD/YYYY

24. **Column X**: Date Resolved – Identifies the date a grievance\complaint was responded to, dates denial notice sent, or date an appeal, IRO, or a denial determination is made. Reporting format: MM/DD/YYYY

25. **Column Y**: Date written notification sent to enrollee and practitioner. Reporting format: MM/DD/YYYY

Note: In order to use GAA information for a comparative data analysis, HCA would like to encourage MCO's to use similar grievance\complaint, action\denial, appeal, categories\reasons as listed in the attached "GAA Standard Categories".